



COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE QUALITY
99 CHAUNCY STREET
BOSTON, MA 02111-1212

Application for Maternal and Newborn Service Designation

Instructions: Please complete a separate application for each hospital campus.

Hospital Name _____

Address _____

City/Town _____ State _____ Zip Code _____

Telephone Number (____) ____-____ Fax Number (____) ____-____

Campus Name _____

Address _____

City/Town _____ State _____ Zip Code _____

Telephone Number (____) ____-____ Fax Number (____) ____-____

Hospital Contact Person

Name: _____

Title: _____

Telephone Number: _____

Please indicate annual birth volume

Calendar years:

2003 _____

2004 _____

2005 _____

Level III only: Percent of all births that are low birth weight infants: _____ %

CURRENT DESIGNATION (CHECK ONE):

- ☐ LEVEL I
- ☐ LEVEL IB
- ☐ LEVEL II Does the existing Level II unit have a Continuous Positive
Airway Pressure (CPAP) waiver? Yes ☐ No ☐
- ☐ LEVEL III
- ☐ LEVEL III (Neonatal Intensive Care Unit ONLY)

REQUESTED DESIGNATION (CHECK ONE) (Please see attached definitions):

- ☐ LEVEL IA
- ☐ LEVEL IB
- ☐ LEVEL IIA
- ☐ LEVEL IIB
- ☐ LEVEL III
- ☐ Freestanding Pediatric Hospital with Neonatal Subspecialty Services
(NEONATAL INTENSIVE CARE UNIT ONLY)

The undersigned requests Department of Public Health designation of the Maternal and Newborn Service as specified above.

Chief Executive Officer or Designee (Print Name)_____

Title_____

Signature_____

Date_____